DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0079	A. BUILDING: _____ B. WING _____	C 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY RIDGE PLACE	5605 JERSEY RIDGE RD DAVENPORT, IA 52807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 26 Number of tenants with cognitive impairment: 10 Total census: 36 The following regulatory insufficiency was cited during the investigation into Complaint #126097-C:	A 000		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 1 of 3 tenants reviewed who displayed behaviors such as exit-seeking and aggression (verbal, physical and sexual) despite interventions (Tenant #1). Findings follow: Record review on 1/27/25 of medical admission records from 7/26/24 revealed Tenant #1 was diagnosed with moderate dementia with anxiety.	A 160	The Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Tenant #1's spouse was looking at placement options for her husband as his memory was getting worse. He was constantly fidgeting and never sat still. He wasn't always aggressive and could be easily redirected.

A progress note identified he moved to the program on 11/14/24. He was noted to be anxious and pacing.

Further record review revealed the following:
- An incident report dated 11/19/24 noted staff was serving dinner when Tenant #1 set off the fire alarm door. He was very agitated when staff approached him. Staff tried to gently redirect him and he swung and hit her in the back of the head with a closed fist.
- An incident report from 11/26/24 identified Tenant #1 was pacing and banging on the doors when he set off an alarm and staff found him in the courtyard.
- The Director of Nursing (DON) updated his service plan on 12/10/24 to add he had a history of aggression toward staff and inanimate objects. Staff were to monitor for what the tenant said or indicated with body language and redirect as necessary.
- An incident report dated 12/11/24 noted a hospice bath aide was trying to redirect Tenant #1 out of another tenant's room because she was trying to give another tenant a bath. Tenant #1 became agitated and swung his fist at the caregiver. The caregiver ducked and he struck a cabinet wall with his closed fist.
- On 12/18/24, an incident report noted the family of a new tenant was moving furniture into the memory care unit at the same time the hairdresser was taking another tenant off the unit for a haircut. Tenant #1 attempted to go through the open door. The hairdresser attempted to

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block the door and keep Tenant #1 from leaving and he swung his right fist at her.
- An incident report dated 12/21/24 identified Tenant #1 walked into Tenant #2's apartment while she was lying in bed. He walked up to her bed with his hands in front of his pants. He was in the process of pulling out his penis when staff called his name and asked him to stop. Tenant #1 became angry, took off his hat and threw it at Tenant #2. His hat hit Tenant #2 to the left of her eye. While throwing the hat, he yelled at Tenant #2, "just roll over and take it." He then picked his hat up from her bed and walked out. Tenant #2 did not have any injuries.
- On 12/22/24, an incident report noted Tenant #3 was sitting on the couch in the common area watching television. Tenant #1 came over and stood above her. Tenant #3 asked him to please move away from her. Staff was walking over to redirect him away from her. Tenant #1 began yelling at her. Staff noticed him balling up his fist when he punched Tenant #3 in the upper part of her left arm. Tenant #3 yelled "ouch" and said "don't touch me." Tenant #1 walked away and started pacing around the floor. Tenant #3 stated she was very afraid of him. Staff contacted the Executive Director who directed her to call 911 for assistance and take Tenant #3 to her room for safety. When the police arrived, they stated they couldn't do much because they couldn't force Tenant #1 to leave. Tenant #1's wife was notified and she took him to the hospital.
- The DON again updated Tenant #1's service plan on 12/23/24 to add interventions to manage his behaviors. Staff were to remove tenants from the area if Tenant #1 became aggressive. They were to administer as needed, or PRN medication, if non-medication techniques were not working for Tenant #1. The plan noted his history of making sexual advances toward a

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female tenant. Staff were to monitor the female tenant when she was in her room and shut/lock her door as necessary. Staff were to redirect Tenant #1 to other activities when he was exhibiting this behavior.
- A progress note from Tenant #1's Primary Care Provider (PCP) documented on 1/14/25 he was seen for a follow up on behaviors, insomnia and medication refusals. Staff reported he was pacing at times. His agitation was increased on the day of the exam, but had improved slightly overall. The PCP was unable to perform an exam as Tenant #1 was aggressive and agitated.
- Tenant #1 met with his PCP on 1/21/25 for a follow-up on behaviors and agitation. He continued to be difficult to redirect often. His moods were often unstable and his exit-seeking behaviors were an ongoing issue. She was unable to perform a physical exam as Tenant #1 was aggressive and agitated. Tenant #1 was noted to be combative toward staff at times. The PCP referred Tenant #1 for a psychiatric evaluation.

On 1/27/25 at 2:41 PM Staff A reported Tenant #1's behaviors were better than when he arrived at the program, but still an issue. He banged on the exit doors of the program. At least one time on each of her shifts he would try and get out of the building. He wandered into other tenant's apartments to take their belongings. If she tried to redirect him, he got worked up and often swung his arm at staff, family members and other tenants. Tenant #1 touched people in a sexual manner. He put his hand on Tenant #2's leg and moved it toward her groin. Staff A redirected Tenant #1 when he touched Tenant #2 inappropriately. One time he tried to put his hand under Tenant #2's pants but she grabbed his hand away. The other times his hand was over

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her pants. He sometimes rubbed her shoulder and arm. She also saw him touch the face and arm of Tenant #4 without her permission. Tenant #4 got aggressive when this occurred. Staff A had told the DON and Executive Director about these things but didn't write incident reports any longer because it didn't seem like anything was done when she documented the events.

On 1/28/25 at 3:45 PM, Staff D said Tenant #1's behavior had improved since he moved to the program, but he still had about 2 outbursts a week. Tenant #1 and Tenant #2 believed they were married and sat close to each other in the common area. She had found Tenant #1 in Tenant #2's bed with his pants undone and had seen Tenant #2 unbuttoning Tenant #1's shirt. When she saw Tenant #1 in Tenant #2's apartment, she directed him out (according to his service plan) but he got angry when she did this. Tenant #2 did not seem bothered by his attention. However, she had noticed Tenant #1 going into Tenant #4's apartment with his pants unbuckled and this concerned her. When she saw this, she escorted him out of the apartment.

On 1/27/25 at 3:50 PM Staff B stated Tenant #1 was physically aggressive toward people and things. If staff asked him to leave a room, he often punched a wall. He also punched at people and had hit a few employees. Tenant #1 gravitated toward Tenant #2. He didn't seem interested in other female tenants. He had rubbed her thigh and back. There were a couple of times he got close to touching Tenant #1's groin, but had not done so. He liked to sit close to Tenant #2. Staff B had not told the DON or Executive Director about her concerns with Tenant #1.

On 1/27/25 at 3:20 PM, Staff C recalled working

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A 160	Continued From page 5 three days on the secured memory care unit the previous week. The first two days were fine. The third day was rough. Tenant #1's wife and daughter came in to help give him a shower. He swung his fist at them. When they left he banged on the courtyard fence which surrounded the program grounds and this went on for quite a while. Staff C was fearful of getting too close to Tenant #1 due to his level of anger. He eventually returned to the building and fell asleep. On 1/28/25 at 11:15 AM the DON and Executive Director reported they were not aware of many of the concerns reported by the staff. They believed Tenant #1's verbal and physical aggression had declined to a manageable level prior to learning of these events. Despite interventions, Tenant #1 continued to act out sexually, and with physical and verbal aggression. He displayed exit-seeking behaviors.	A 160		

Department of Inspections and Appeals
Attn: Catie Campbell
6200 Park Avenue Suite 100
Des Moines, Iowa 50321

Dear Ms. Campbell:

On behalf of Jersey Ridge Place, I respectfully submit our Plan of Correction for your approval. This response is specific to the Complaint # 126097 Visit, for the onsite visit 1/27/2025-1/28/2025. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

69.23Criteria for admission and retention of tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression.

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Program and Tenant #1's family are actively searching for alternative placement for the tenant.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing was re-educated on admission and retention of tenants.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Designee will audit tenant's health, functional and service plans, ongoing, to ensure they are following regulatory requirements, related to admission and retention criteria.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before March 27, 2025.

If you have any questions regarding this plan of correction, please contact me at 563-355-2027.

Respectfully submitted,

Nichol Gillies, Director